The retinal pigment epithelium (RPE) can undergo reactive hyperplasia and metaplasia following a variety of ocular insults. However, true neoplasms of the RPE are rare. We report a case of a papillary adenocarcinoma of the RPE arising in the blind staphylomatous right eye of a 79-year-old woman with a long history of bilateral posterior staphylomas who was seen with increasing pain and exophthalmos of the right eye. Findings from ultrasonography and computed tomography demonstrated linear calcification consistent with osseous metaplasia of the RPE. Progression of the exophthalmos and worsening exposure keratitis led to enucleation of the eye. Gross pathology showed a 79-mm-long globe. Histopathologic findings revealed a largely amelanotic papillary adenocarcinoma arising from the RPE. Positive immunoreactivity for cytokeratin supported the epithelial origin of the tumor. Adenocarcinoma of the RPE is rare but may develop in a blind eye.

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True malignancies of the retinal pigment epithelium (RPE) are extremely rare. The RPE, however, can be involved in a remarkable variety of pathologic processes including reactive hyperplasia, congenital hypertrophy, combined hamartoma, and, less commonly, adenoma. We report herein a case of an adenocarcinoma of the RPE found in a blind eye with a large posterior staphyloma.

**REPORT OF A CASE**

A 79-year-old white woman was seen with increasing pain and exophthalmos of the right eye. The vision in the right eye had been poor since childhood following an alkali burn. Ten years prior to our seeing her, the vision in that eye had been noted to be no light perception. Cataract surgery was performed on the left eye, but her vision remained hand motions because of extensive myopic degeneration and posterior staphyloma. Beginning 3 months prior to our seeing her, her right eye had become increasingly prominent and painful.

Findings on examination revealed that the right eye could not perceive light and was 9-mm proptotic by Hertel exophthalmometry. The cornea was completely opaque, precluding a view of the fundus, and the episcleral and conjunctival vessels were diffusely vasodilated. There was marked limitation of extraocular movement in all directions of gaze. The intraocular pressure OD was 55 mm Hg. The visual acuity was light perception in the aphakic left eye with an intraocular pressure of 15 mm Hg. Findings on fundus examination showed a large posterior pole staphyloma and extensive myopic degeneration.

Orbital computed tomographic findings revealed anterior displacement of the right eye by a massive staphyloma and linear calcification along the eye wall. The solid, well-circumscribed staphyloma was heterogeneous in density and was continuous with the posterior pole of the globe. The left eye showed a posterior staphyloma. Magnetic resonance imaging findings showed a heterogeneous signal in the right eye slightly higher than that of the left eye. Linear signal voids on both spin-echo sequences were related to intraocular calcification. The
massive staphyloma involving the right eye showed a heterogeneous signal with hyperintense foci on T1-weighted images and hypointense/hyperintense foci on T2-weighted images suggestive of blood products (oxyhemoglobin/methemoglobin). The staphylomatous left eye demonstrated a normal low signal intensity on T1-weighted images and high signal intensity on T2-weighted images.

The patient was followed up closely for 9 months and was found to have increasing exophthalmos of the right eye (13 mm) and worsening exposure keratitis with corneal epithelial breakdown. Because the eye was blind and painful, with chronic corneal exposure and imminent corneal ulceration, enucleation was recommended. Using a modified enucleation approach with lateral canthotomy, the globe and massive staphyloma were removed in their entirety and fixed in formaldehyde.

**PATHOLOGIC FINDINGS**

Macroscopically, a dark brown mass with a smooth multinodular surface protruded from the posterior surface of the firm right globe. The anteroposterior length of the eye and posterior mass was 79 mm. The cornea was scarred and opacified. The globe contained bone, necessitating decalcification prior to sectioning. After sectioning, tan to brown tumor tissue mixed with blood was found to fill the interior of the globe and posterior staphyloma.

Microscopically, a thick layer of dense collagen incorporating large quantities of metaplastic bone covered the inner surface of the choroid. Retina was not identified. A papillary neoplasm composed of polarized, cuboidal, and columnar epithelial cells with moderately pleomorphic round to oval nuclei and nucleoli filled the remaining interior of the globe and posterior staphyloma.

Although the tumor was largely amelanotic, a few strands of cells contained melanin, suggesting origin from the RPE. Twenty-eight mitotic figures were counted in 40 high-power fields. Focal necrosis and extensive intralesion hemorrhage were present. Parts of the clotted blood were markedly atrophic remnants of the iris and ciliary body. A thick layer of dense collagen incorporating large quantities of metaplastic bone covered the inner surface of the choroid. Retina was not identified. A papillary neoplasm composed of polarized, cuboidal, and columnar epithelial cells with moderately pleomorphic round to oval nuclei and nucleoli filled the remaining interior of the globe and posterior staphyloma.
degenerated and contained cholesterol clefts and large amounts of hematoidin and hemosiderin pigment consistent with chronicity.

The tumor cells showed intense (+4) positive immunoreactivity for cytokeratin cell adhesion molecule marker CAM 5.2 (Figure 6) and moderately intense (+2 to +3) local immunoreactivity for low-molecular weight cytokeratin AE-1 and vimentin. Staining for melanoma-specific antigen HMB-45, carcinoembryonic antigen, S100 protein, and high-molecular weight AE-3 was negative.

Figure 5. Top, Amelanotic epithelial cells composed of papillary adenocarcinoma rest on prominent connective tissue septae. Cells show mild nuclear pleomorphism (hematoxylin-eosin, original magnification ×100). Bottom, Arrows denote septa in this higher-magnification photomicrograph (hematoxylin-eosin, original magnification ×250).

Figure 6. Neoplastic epithelium composed of papillary tumor exhibits intense positive immunoreactivity for cytokeratin cell adhesion molecule marker CAM 5.2 (immunoperoxidase, original magnification ×50).

COMMENT

Although the RPE rarely gives rise to true neoplasms,1-3 it readily undergoes reactive hyperplasia and metaplasia following trauma, inflammation, or degenerative processes that involve the choroid or retina. This may also occur without apparent cause.

Adenoma and adenocarcinoma of the RPE are both extremely rare. It is usually impossible to distinguish between them clinically.1-4 There are only a few well-documented cases of adenocarcinoma of the RPE.4-6 These malignancies tend to exhibit local invasiveness into the choroid and sensory retina. However, to the best of our knowledge, there are no histologically proven cases of adenocarcinoma of the RPE that have metastasized to other sites. Although 3 deaths from metastatic tumor were reported by Garner,7 none of the metastases were confirmed histologically. Loeffler et al7 reported a case of RPE malignancy with suspected extraocular extension. Some authors believe that an adenocarcinoma of the RPE with extraocular extension is capable of metastasis to distant sites.8

Tumors of the RPE usually occur in the peripheral retina but may occur close to the optic disc. Vitreous seeding may occur if the tumor breaks through sensory retina. Histopathologically, tumors of the ciliary pigment epithelium and RPE are classified into vacuolated, tubular, and mixed types. The more anterior tumors tend to be vacuolated whereas the more posterior ones tend to be tubular.1,2 Immunohistochemistry findings may demonstrate immunoreactivity for low molecular weight cytokeratins, vimentin, and S100 protein, which is consistent with the neuroectodermal origin of the cells.7,6

Our case is interesting for several reasons. This tumor was present in a staphylomatous globe that was enucleated for other reasons. The tumor was not diagnosed preoperatively as there was no view of the fundus clinically. In retrospect, there may have been a suggestion of a solid mass lesion on imaging studies, but the presence of an intraocular tumor was not a serious consideration in the decision to perform the enucleation. This scenario is similar to the case of Loeffler and associates.7

In our case, the soft tissue definition of computed tomographic studies was insufficient to differentiate a solid neoplasm from a hemorrhagic process. The excellent soft tissue contrast of magnetic resonance imaging studies was also unable to differentiate the hemorrhagic from the neoplastic component within the lesion. Furthermore, the relatively poor histopathological specificity of magnetic resonance imaging does not readily allow differentiating primary from secondary uveal or retinal tumors.10

This papillary malignancy was found coincidentally on histopathological sectioning of the globe. Following histopathological diagnosis, it was decided not to treat the patient with radiation and/or systemic chemotherapy due to her age, fragile health, and because the mass was excised in its entirety with no evidence of orbital seeding. At 6 months following the enucleation, the patient continues to do well with no evidence of metastatic disease or orbital recurrence. It is known that reactive hyperplasia of the RPE may occur secondary to trauma or inflammation. It has been suggested that hyperplasia of the RPE may rarely transform into a malignant tumor.5,7 In the case reported here, there was a history of ocular trauma and chronic inflammation. Although the most frequent malignant intraocular tumor in phthisical eyes is choroidal melanoma, other malignancies including adenocarcinoma of
the RPE must still be considered. We speculate that this malignant neoplasm may have arisen from RPE hyperplasia secondary to chronic inflammation, similar to previous published cases.4,7 In any eye with opaque media and a history of trauma, an underlying neoplasm should be considered.

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REFERENCES


ARCHIVES OF OTOLARYNGOLOGY—HEAD & NECK SURGERY

The Effect of Blepharoplasty on Eyebrow Position
Andrew S. Frankel, MD; Frank M. Kamer, MD

Objective: To determine if upper eyelid blepharoplasty causes eyebrow position to drop in a cosmetic surgery population.

Design: Retrospective, observational study. A treatment group that underwent upper eyelid blepharoplasty was compared with a matched control group that did not undergo the surgery.

Setting: Private facial plastic surgery practice. All surgery was performed at an ambulatory surgical facility on an outpatient basis.

Patients: A total of 82 patients (164 eyes) were included in this study: 54 (8 men and 46 women; average age, 46.8 years) in the treatment group and 28 (6 men and 22 women; average age, 43.8 years) in the control group. The treatment group was chosen in a retrospective fashion to include only those patients (1) for whom preoperative and postoperative photographs were available and (2) who had undergone upper eyelid blepharoplasty by the senior author (F.M.K.). These patients underwent no other procedures, either before or during the time span between the photographs, that could affect eyebrow position. The control group consisted of patients who had an available set of matching photographs taken over time. These patients did not undergo blepharoplasty or any other procedure that could alter eyebrow position between their initial and final photographs.

Intervention: Upper eyelid blepharoplasty performed by the senior surgeon (F.M.K.). The surgical technique was identical in all cases.

Outcome Measure: The change in eyebrow height reflected as a percentage of the pretreatment height. Results are based on measurements taken from standardized photographs.

Results: Original treatment and control groups of 108 and 56 eyes, respectively, were restricted to a smaller number to create similar populations for comparison. Therefore, 40 eyes in the treatment group were matched with 28 eyes in the control group to control for the duration between measurements. A t test found no significant difference (P = .94) in eyebrow height between patients who had a blepharoplasty and those who had not.

Conclusion: In a cosmetic surgery population, upper eyelid blepharoplasty does not cause a lowering of the eyebrow. Arch Otolaryngol Head Neck Surg. 1997; 123:393-396

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